Commitment to Serving Downtown San Jose
Regional Medical Center of San Jose

Introduction

Regional Medical Center of San Jose (RMCSJ) is committed to providing health services to downtown San Jose. This community is a key part of the service area of RMCSJ. This paper is designed to provide interested citizens with information about important accomplishments of RMCSJ and its plans for continuing to serve this community.

Executive Summary

- The closure of San Jose Medical Center (SJMC) and the unification of SJMC and RMCSJ avoid reduction of access to medical care services in the community.
- It was no longer financially feasible to continue operations of SJMC; continuing to attempt to do so was leading to the collapse of both SJMC and RMCSJ.
- RMCSJ is the 2nd largest provider of care to Medi-Cal beneficiaries in the area; RMCSJ is committed to maintain and expand services to Medi-Cal patients.
- Travel time for residents of zip codes closest to SJMC to the now current nearest hospital are shorter than for more than half of the zip codes in the County.
- Local hospitals have adequate capacity to serve the County for the long term.
- RMCSJ will establish significant healthcare services in the downtown area.
- Building a modern 200-bed hospital on 5 acres of the SJMC site would not be practical, nor economically feasible to operate.

Closure of SJMC and Unification of SJMC and RMCSJ Avoids Reduction of Community Access to Medical Care

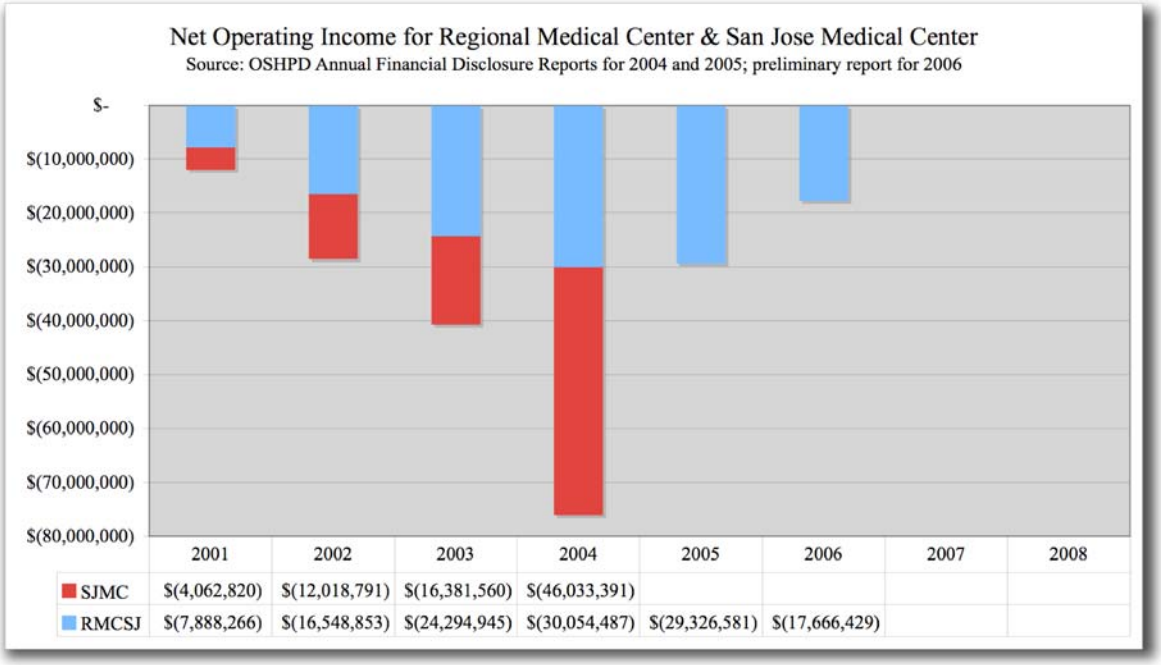
HCA carefully considered whether it would be financially feasible to continue to operate two hospitals (SJMC and RMCSJ) 3 miles apart from one another in the central and eastern portions of Santa Clara County. After 5 years of rigorous management attention, it was concluded that it was not financially feasible.[1] There are two reasons for this conclusion:

1. The proportion of patients without insurance and patients with public health insurance coverage (such as Medi-Cal that has low rates of payments) is relatively high in the central and eastern portions of Santa Clara County. This makes it difficult for hospitals to have enough revenue to cover costs of providing the care. Other than the County hospital (which is supported by local taxpayers), no hospitals in Santa Clara County served more low-income people than SJMC and RMCSJ.

[1] Some in the community have questioned why hospitals with similar payer mixes are able to be profitable. Please see the Appendix for an analysis of how this happens.

2. The costs of operating two hospitals so close together resulted in relatively low utilization of high fixed cost services (intensive care, specialized surgery, specialized diagnostic services such as CT and MR scanners) at each campus.

The unification of the programs of SJMC and RMCSJ will be successful in bringing about a financially sustainable hospital to serve the central and eastern portions of the County. This is evidenced by the following financial data.



The 2004 losses are somewhat overstated because, with the wind down of SJMC and the transfer of services to RMCSJ, this was a year of transition with extraordinary costs. What this chart demonstrates though is that the financial performance of both SJMC and RMCSJ was deteriorating between the years 2001 to 2004, and that it would not be financially feasible to continue operating two hospitals 3 miles apart in central and eastern Santa Clara County. Financial performance has shown a substantial improvement since the SJMC closure and unification of the two hospitals. Only by combining these two hospitals is it financially feasible to operate a hospital in these communities.

It is expected that in coming years RMCSJ will reach breakeven and move to positive net operating income. The $80 million medical office building nearing completion and the $155 million being spent on a new inpatient wing, new central plant, ICU expansion, emergency department renovation and expansion, expansion of cardiovascular services, expansion of surgical services, renovation of obstetrical services, new MRI, new rehabilitation services area, and expanded parking evidence this. HCA has taken the only practical and responsible step available to provide hospital services to central and eastern Santa Clara County. If HCA had continued to attempt to maintain operations of both hospitals, it would likely have lead to the failure of both hospitals and thereby reduced access to needed medical care services in the community.

RMCSJ is a Major Provider to Medi-Cal Beneficiaries

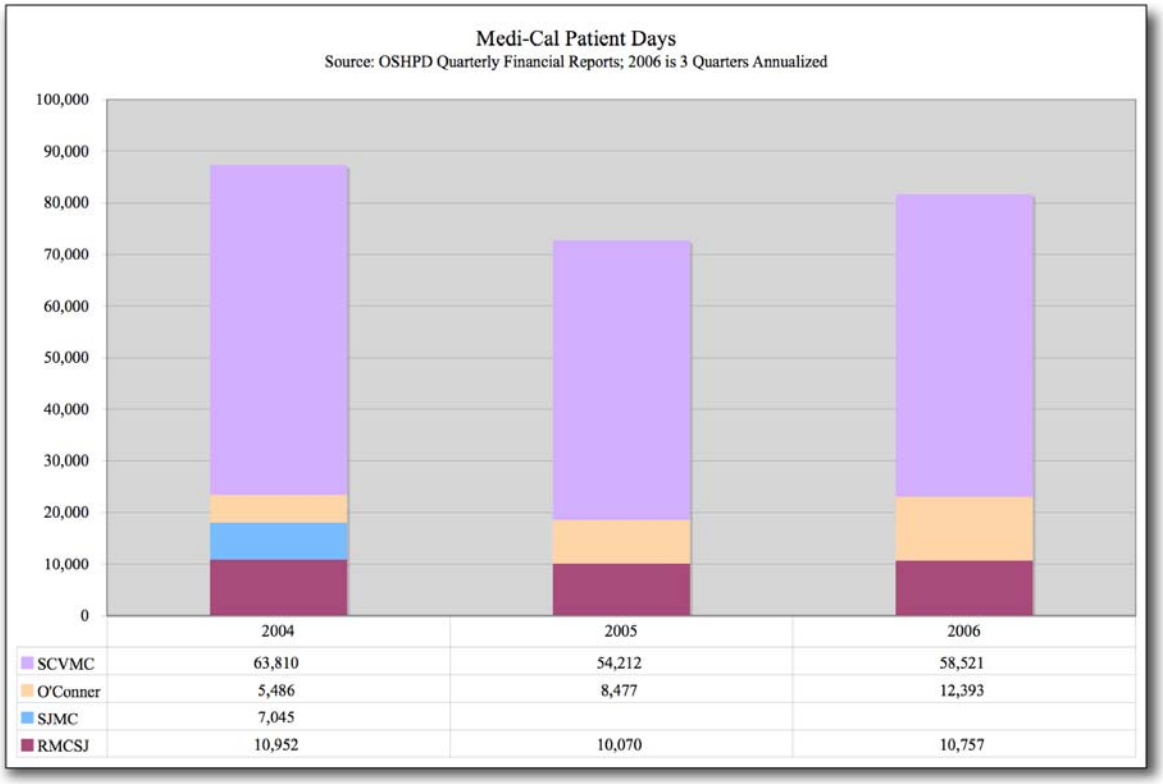
Since Fall 2004[2], RMCSJ has been unable to provide elective hospital services to Medi-Cal beneficiaries. RMCSJ and the State Department of Health Services were unable to agree upon contract rates for a *certain narrow group of services*—non-emergency inpatient services. Some members of the community who have assumed that RMCSJ is not able to provide services to *any* Medi-Cal beneficiaries have misunderstood that this *only* affected elective and obstetrics services. In fact, RMCSJ is able to provide most services to Medi-Cal beneficiaries including:

- Emergency inpatient care;
- Emergency outpatient care;
- Outpatient surgery;
- Outpatient diagnostic services (such as laboratory and radiology);
- Outpatient treatment services (such as physical therapy, radiation therapy).

Not only is RMCSJ currently a significant provider of Medi-Cal services, it is planning to expand services to Medi-Cal beneficiaries. RMCSJ's facility planning is based on the expectation that it will successfully re-engage the State Department of Health Services and reach agreement on a reasonable reimbursement rate (in much the same way that its affiliated HCA hospital, Good Samaritan Hospital, has done for providing elective services to Medi-Cal patients). As a result, current facility plans for RMCSJ are being designed to accommodate resumption of non-emergency inpatient services to Medi-Cal beneficiaries.

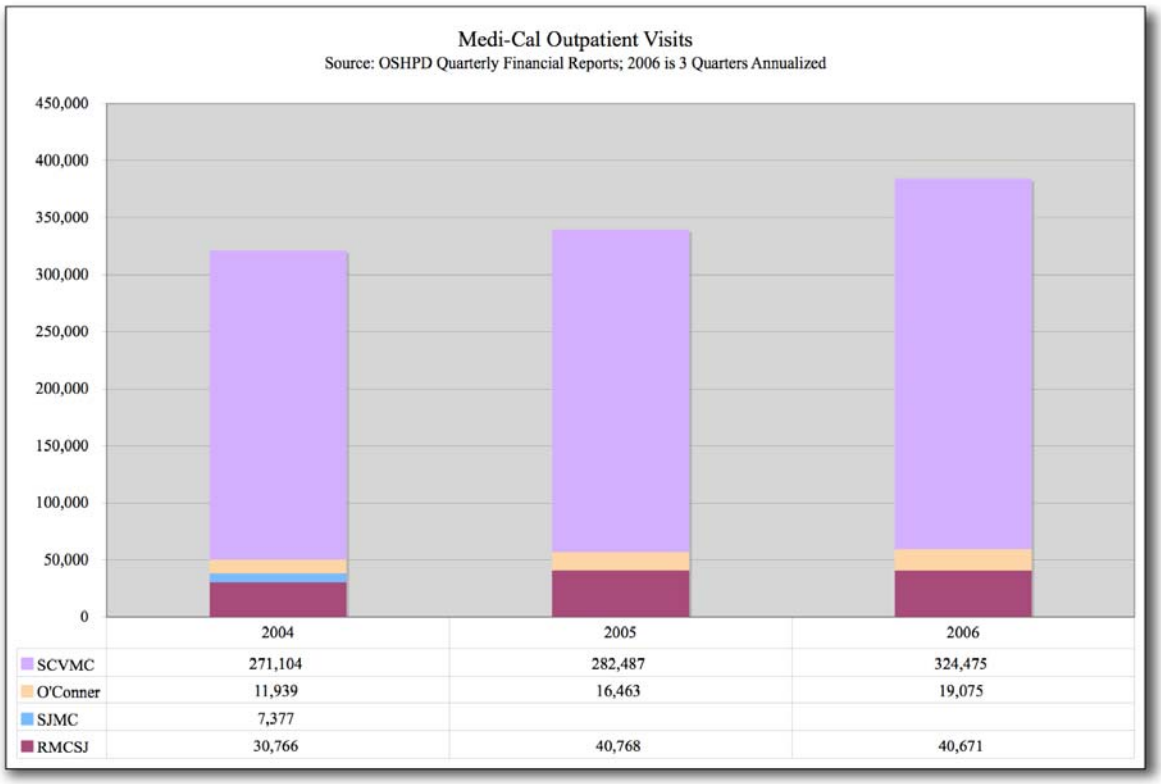
The chart below demonstrates what has happened to Medi-Cal inpatient days at relevant community hospitals since the closure of SJMC.

[2] In November 2004 the Medi-Cal fee-for-service agreement between RMCSJ and the State Department of Health for elective services was not renewed and in October 2006 the Medi-Cal Managed Care contract with RMCSJ for elective services was not renewed.

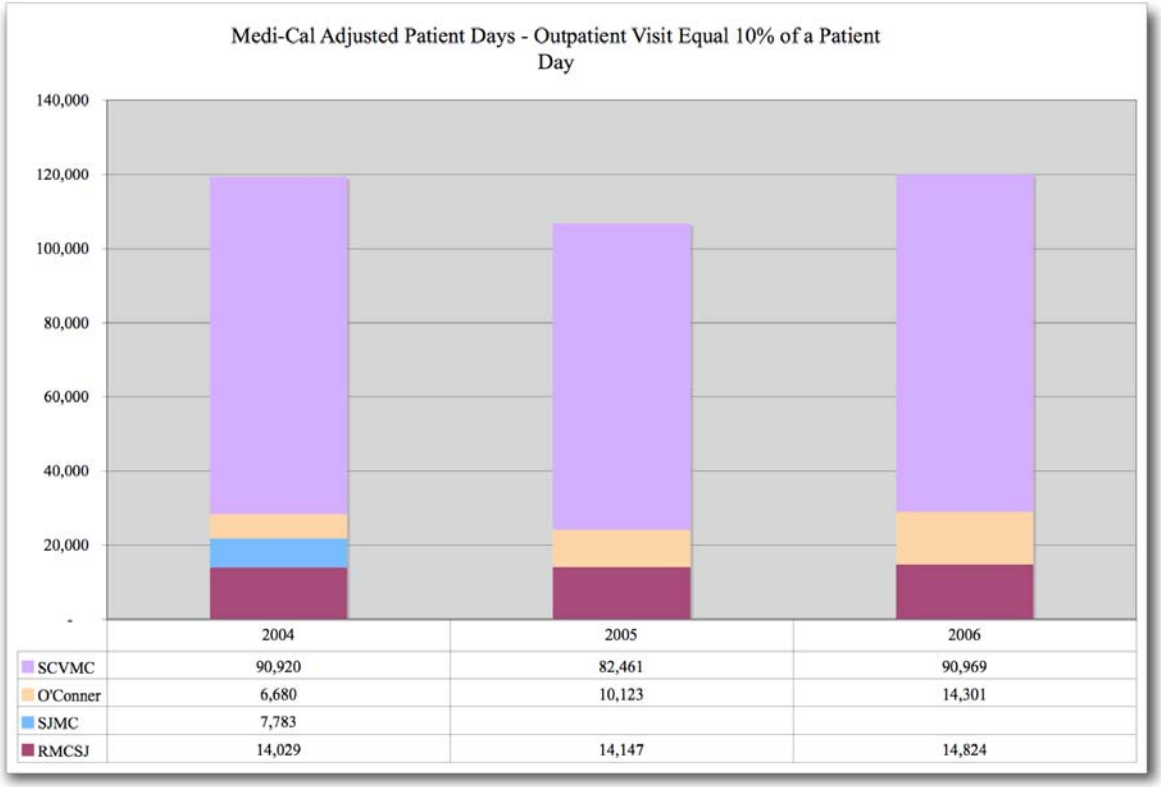


The unsuccessful negotiations between RMCSJ and the Department of Health Services in Fall 2004 led to a modest 8% drop in Medi-Cal patient days at RMCSJ in 2005. This is due to the fact that there are relatively few Medi-Cal elective surgeries and obstetric cases are generally short stay. Most Medi-Cal admissions are emergency admissions and RMCSJ continues to provide emergency services to Medi-Cal patients.

With the closure of SJMC, Medi-Cal outpatient visits at RMCSJ rose by 33% in 2005 and have stayed at that level for 2006 as shown in the graph below.



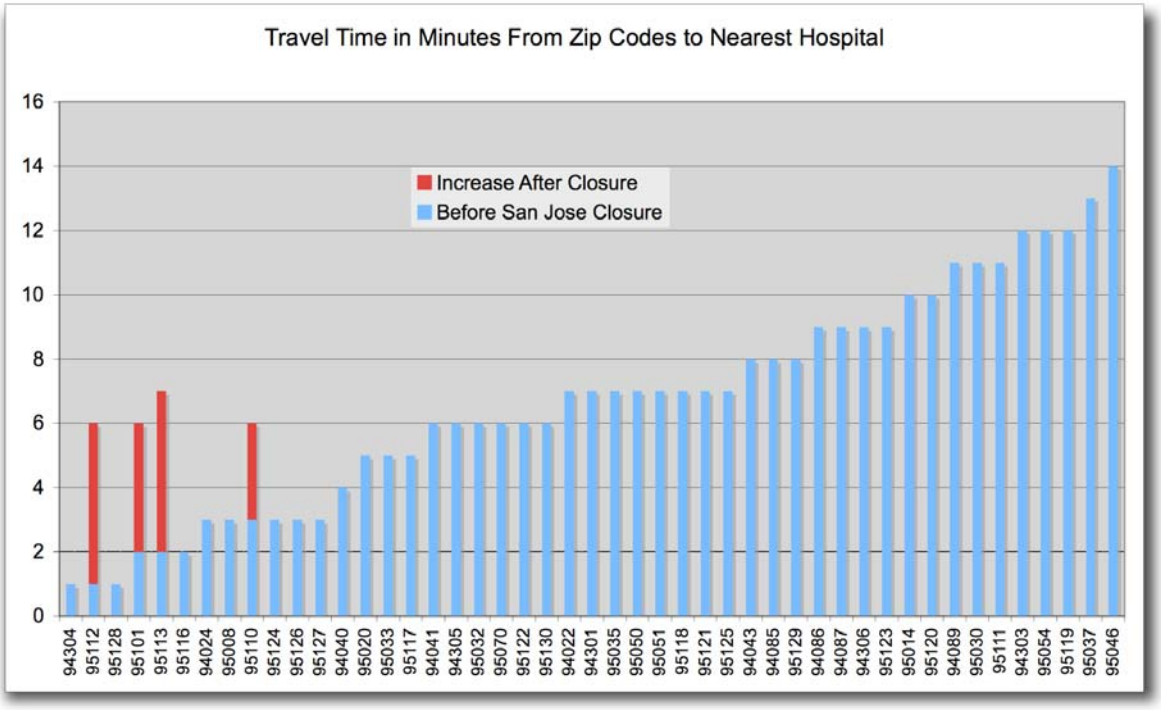
An average outpatient visit consumes approximately 10% of the resources that an inpatient day consumes. By adding 10% of the outpatient visits to the patient days yields the following adjusted patient days.



This chart demonstrates that the level of service RMCSJ has been providing to Medi-Cal beneficiaries has actually been growing over the last 3 years and that, even without a contract for elective inpatient Medi-Cal services, RMCSJ is providing more service to Medi-Cal beneficiaries than O'Conner Hospital.

Travel Time for Emergency Care is Excellent Even Without a Downtown Hospital

The chart below shows travel times in minutes[3] from the major zip code areas in Santa Clara County to the nearest hospital.



The focus is on the 4 zip codes closest to SJMC (95112, 95101, 95113 and 95110). This chart shows:

- Travel time for emergency care for most communities is between 4 and 12 minutes. This range is consistent with good emergency medical care planning principles.
- Before the closure of SJMC, some of the zip codes closest to SJMC had among the best travel times for emergency care; after the closure of SJMC all of the downtown communities have travel times of 6 to 7 minutes (which is below the average for the County and below the travel time for more than 58% of other zip codes in Santa Clara County).

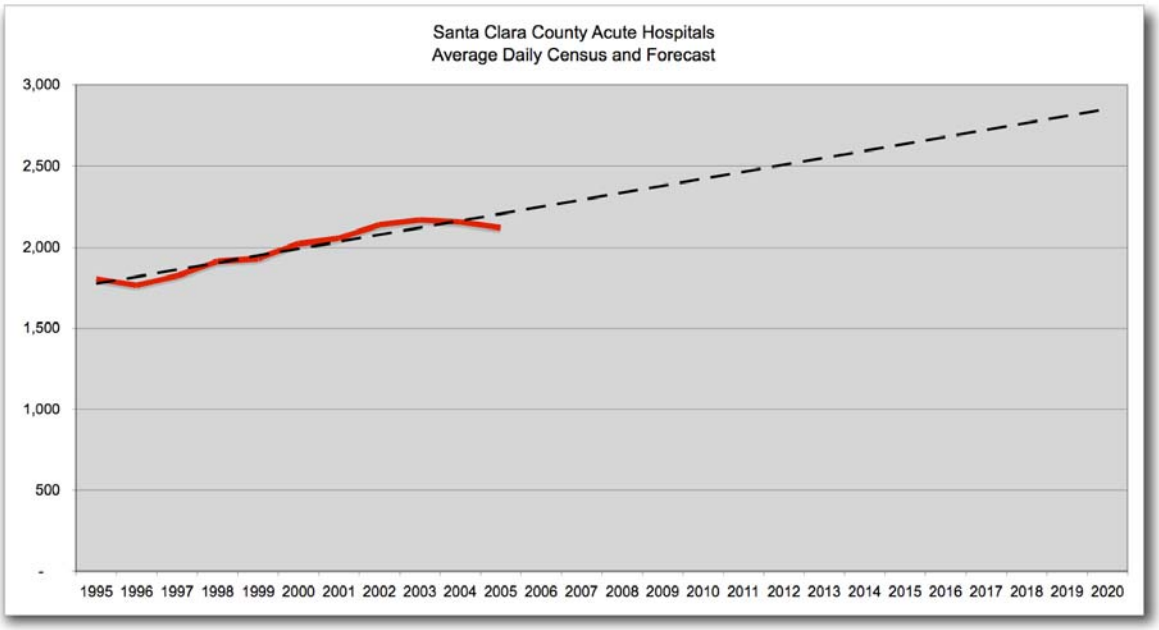
Additionally, because RMCSJ is a designated trauma center, the downtown communities have better access to trauma center care than most communities in the County.

[3] Taken from Google Maps

Local Hospitals Have Adequate Capacity for the Long Term

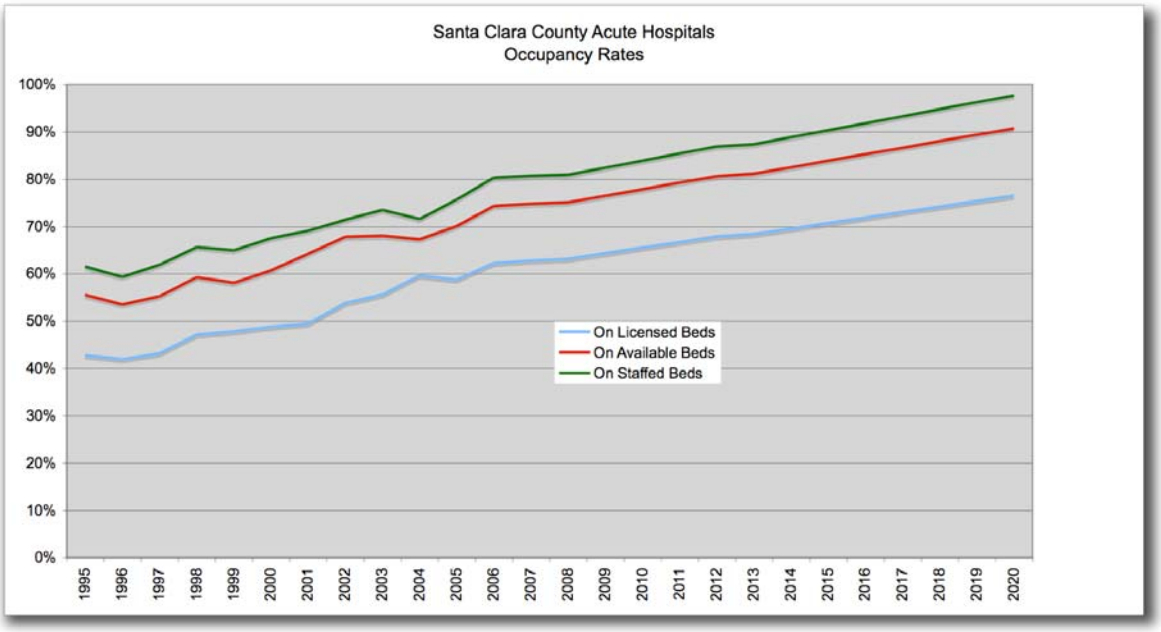
Even after the closure of SJMC, the hospitals in Santa Clara County currently have adequate licensed bed capacity to handle the expected growth in demand through 2020. This analysis includes the expansion in bed capacity now underway at RMCSJ and at other hospitals in the community. Beyond these committed expansions in capacity, each of the hospitals in the community has demonstrated the capability and willingness to expand in advance of increasing demand.

The chart that follows shows a forecast of hospital demand through 2020 for Santa Clara County. This forecast is based on the assumption that the historical trend of growing utilization will continue with growing population and aging population increasing demand with some offset to this growing demand from improving technology of advanced less invasive surgical and diagnostic techniques, improving pharmaceutical treatments and improved hospital efficiency.



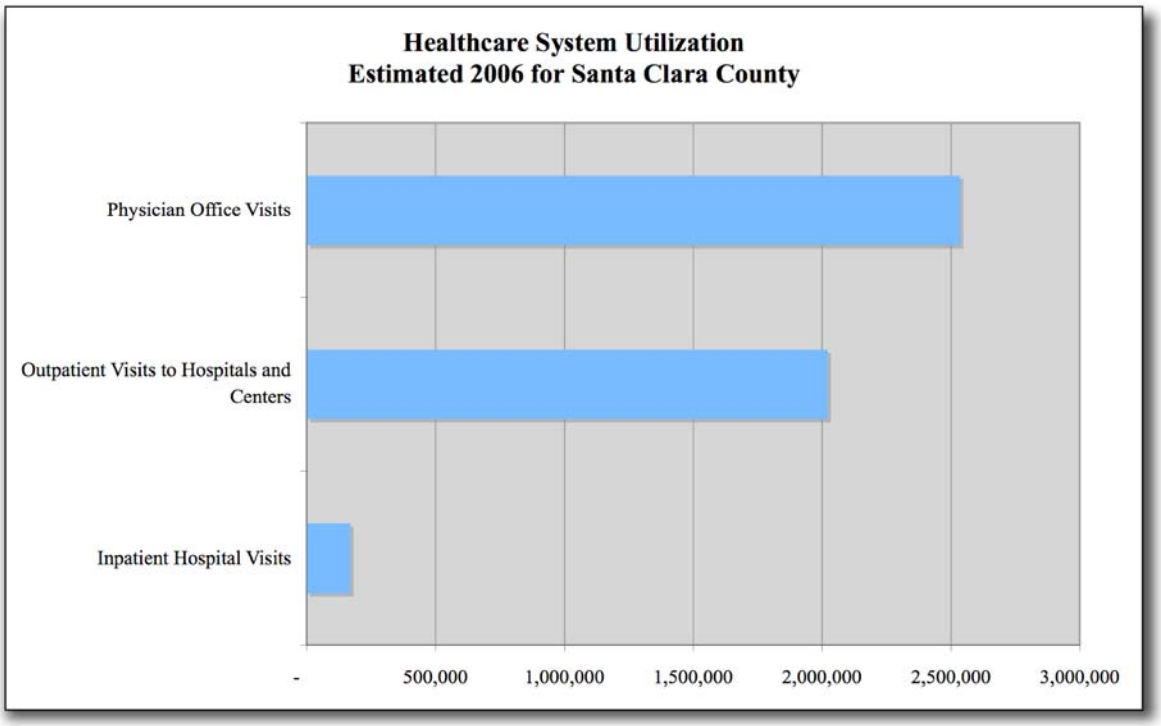
The following chart shows a forecast of average occupancy rates through 2020. This forecast assumes the growth rate of demand shown in the graph above and current capacity with the expansion currently underway at RMCSJ and other hospitals in the community. An average occupancy rate of 80% or less provides good access to hospital services. Thus, it is evident that since occupancy rate for licensed beds will be no higher than 75% by 2020, there is adequate capacity at existing hospitals and no need to establish an additional hospital. [4]

[4] As they have in the past, hospital would—as needed—increase available and staffed beds to full licensed capacities.



Hospitals Represent Only One Component of Comprehensive Healthcare Services

Hospitals are the most prominent (and costly) component of the healthcare system. At the same time, however, when planning for healthcare services, it is important to keep in mind that hospital services represent only one component of comprehensive healthcare services. The graph below represents estimated visits to the healthcare system scaled according to *the number of patient visits.*



As indicated by this chart, an ideal geographic distribution of healthcare services would be based on the following principles:

- Assure access to emergency services within general planning guidelines;
- Primary care services (including urgent care services) and basic diagnostic services located close to neighborhoods;
- Hospitals located throughout the region, but limited in numbers so that these high cost resources can be efficiently utilized.

RMCSJ Will Establish Significant Healthcare Services Downtown

Contrary to the perception of some in the community that HCA is neutral with regard to revitalization of the downtown area, RMCSJ (along with the City and the community) favors the redevelopment of the site of the former SJMC with mixed uses that include residential, retail and medical and healthcare services. Along with the City and community, RMCSJ also supports the building of health facilities in the area. RMCSJ believes that a feasible medical and healthcare services model may include:

- Urgent Care Services. RMCSJ is interested in directly providing these services. These would be services for urgent medical care needs, but would not include a licensed full service emergency service since the downtown is well served by several full service emergency departments including a trauma center at RMCSJ.
- Diagnostic Services (laboratory services, imaging services). RMCSJ is interested in directly providing these services.

The redevelopment favored by RMCSJ would establish a vibrant center of residential and commercial activity and establish revitalized healthcare services that meet the needs of the community and are economically self-sustaining. The development would be planned to be compatible with both the existing and emerging surrounding residential communities to the north and south of East Santa Clara Street and with the emerging commercial development along East Santa Clara Street from San Jose State University and the new City Hall at 7th Street and to Roosevelt Park at 17th Street.

Additionally, private investors in medical office buildings may redevelop additional medical office space to complement the residential and commercial development and the urgent care service and diagnostic services development planned by RMCSJ.

Land Required for a Modern Hospital

Would a Contemporary Hospital and Essential Related Facilities Fit on the Former SJMC Property?

KMD Architecture has looked at how well a moderate size (200 bed) hospital designed to contemporary standards and supported by appropriate parking, entries and drives, and on-site outpatient facilities and medical offices would fit on the campus of the former SJMC.

KMD finds that there are the following drawbacks associated with attempting to place a hospital on a 5 acre parcel:

1. If a parking structure is to be placed on the property, the full complement of outpatient facilities and physicians offices that would normally be found surrounding a hospital may not be accommodated on the campus; leading to severe operational inefficiencies and to an insufficient physician presence to support a hospital.
2. If the full complement of outpatient facilities and physician offices are placed on the campus, there is no room for on-site parking.
3. The campus would be a high-density development. The table below demonstrates by comparison to similar size hospitals how small the SJMC site is.

Hospital	Acreage	Times larger than SJMC
RMCSJ	35.70	7.2
O'Conner	17.00	3.4
Kaiser Redwood City	20.00	4.0
Washington Township	35.35	7.1
El Camino	27.00	5.4
John Muir Concord	28.80	5.8
Legacy Salmon Creek	23.00	4.6
Average	26.69	5.3

4. Retention of site areas for future incremental growth and for phased replacement of facilities as they become obsolete would be impossible.

This property is far from an ideal site for a contemporary hospital of the size proposed. A larger property would be more appropriate so that future development (the parameters of which may not be foreseen at this time) and phased replacement could be accommodated.

Elements that would need to be accommodated on-site for purposes of the "fit study" include:

- Hospital of 420,000 building gross square feet (BGSF) (2100 BGSF per bed)
    - Ground Level (partially below grade): Administrative and Support Services including Dietary Services, Central Sterile Processing and Central Stores
    - First Floor: Public entry, Administration, Emergency Services and Diagnostic Imaging
    - Second Floor: Surgery, Interventional Services and Intensive Care Nursing Unit
    - Third Floor: mechanical and electrical floor serving lower floors
    - Floors Four, Five and Six: Medical / Surgical and Intensive Care Inpatient Nursing Units
    - Penthouse level for mechanical and electrical equipment
- Central Plant with Service Yard
- Parking structure: 1,680 parking spaces (548,000 BGSF)

- Public entry drive and drop-off / pick-up areas at each building
- Emergency 'Walk-in" entry with drop-off / pick-up area and dedicated parking
- Ambulance entry drive with bays for 4 ambulances, 11 parking spaces for police cars and on-call ambulances and space for a fire-truck to turn around.
- Loading dock and service yard for delivery of supplies, food and equipment, and for removal of trash, garbage, recyclable materials, soiled linen, biological waste and radioactive waste
- Outpatient Services and Medical Office Building(s) (180,000 BGSF)
- Space for incremental growth of departments and for facilities for limited new initiatives
- Space for future phased replacement of facilities as they become obsolete. This space should be located to retain key functional relationships among services and to minimize disruption of continuing operations.

Why Hospitals and Hospital Campuses Today Have More Area Per Bed Than in The Past

Hospitals today are considerably larger relative to bed capacity than has been the case historically. In fact, a "typical" community hospital has about twice as much area per bed as was the case as little as twenty-five years ago. (1,000 SF / Bed in 1970's to 2,000 SF / Bed in 2000 and today slightly more.) A variety of factors have contributed to this increase.

In general, hospital size increases have resulted from facility responses to:

- Higher average inpatient acuity
- Shorter average lengths of patient stays
- Increased levels of staffing
- Evolving technologies
- Commitment to greater safety, security and confidentiality
- Emphasis on improved operational efficiency, productivity and access
- Changing community demographics
- Changes in philosophies of care
- Competition for qualified physicians and staff
- Increasing numbers of sophisticated hospital-based outpatient procedures (requiring less than twenty-four hour stay).

Whether driven by efforts to achieve higher quality of care, by evolving technologies, by economic incentives or by legal mandates of codes and legislation, the end result has been facilities that require considerably more space per bed.

Some of the specific building elements that are part of the area increase are:

- Single patient bedrooms rather than semi-private or multiple patient bedrooms. Patient bedrooms that include larger clearances around the bed (which is also larger-sized), a separate staff zone with counter and sink, a separate family zone with sitting and sleeping accommodations and other amenities.
- Private patient toilet / shower rooms for every patient room sized to allow staff assistance for the patient.

- A number of patient bedrooms and toilet / shower rooms designed to meet accessibility standards for handicapped patients and to accommodate obese patients.
- Greater percentage of patient bedrooms for isolation of / from infectious agents designed with transition vestibules, air pressure differentials, more frequent air change intervals, higher levels of air filtration and exhaust.
- Greater number and more widely distributed staff workstations to afford greater proximity to and observation of patients.
- Greater number, larger and more widely distributed clinical support spaces such as medication rooms (for secured storage, refrigerated storage, and preparation), clean supply rooms, equipment rooms, copier and printer rooms, etc. for proximity to staff workstations and patient care areas.
- Larger operating and interventional procedure rooms, with adjacent control and equipment rooms, for larger surgical teams, more equipment (including in some cases robotic surgery equipment and multiple imaging modalities) and flexibility for multiple uses.
- Larger outpatient prep and recovery areas to support sophisticated hospital-based procedures and those for high risk outpatients not expected to require twenty-four hour or greater stay in the hospital.
- One or more elevators sized for patient transfers with capacity for patient bed, a team of caregivers and supporting equipment.
- Information technology "closets" that are now six to eight times as large as in the past.
- Staff work environments that are more ergonomically designed, supplemented with respite areas and amenities.
- Conference and meeting areas for multidisciplinary collaboration among physicians and other caregivers.
- Waiting areas with greater variety of settings for family groups, larger sized and more separated than in traditional hospitals.
- Larger mechanical and electrical rooms and shafts.
- Larger structural elements such as columns, braced walls, and shear walls.

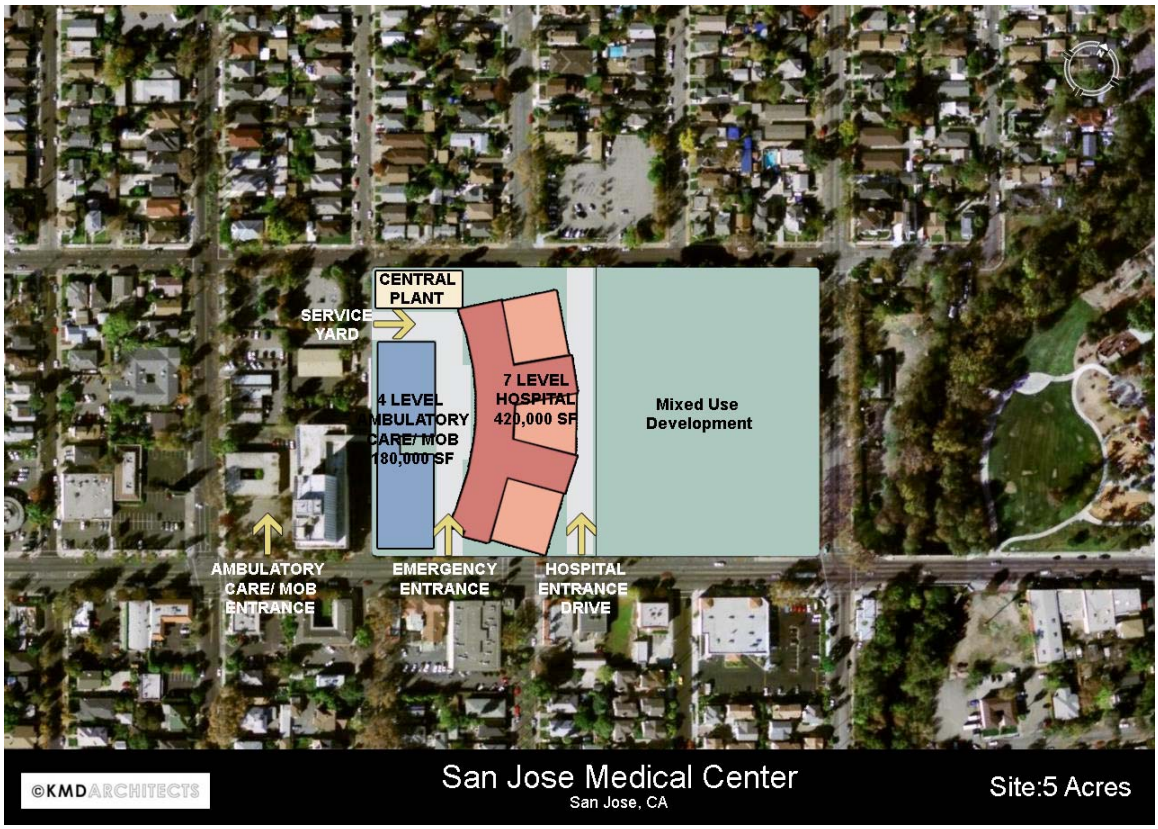
Beyond factors that have increased the size of the hospital itself, the continuing shift of diagnosis and treatment services (once provided in inpatient settings but have now shifted to outpatient settings) results in the need for more outpatient facilities, a portion of which need to be adjacent or proximate to the hospital. Some physicians and physician groups also derive mutual benefits with the hospital if located on the hospital site and preferably in facilities linked to the hospital itself. In California (because of the significant differences in building codes, building permit review processes and construction costs for hospitals and for outpatient facilities and Medical office buildings) the inpatient and outpatient facilities are typically separate but linked buildings. Such links not only allow greater physician and staff efficiency, but reduce duplication of facilities, equipment and staff by allowing use of less expensive outpatient services by inpatients where they make up less than twenty-five percent of the service volume.

Parking demand for hospitals has increased from historical norms. This is due in part to more intensive levels of staffing, in part to more rapid throughput of many services, and in part to demographic changes in communities. For master planning purposes, KMD recommends 3.85 cars per hospital bed plus 6 cars per 1000 SF of useable space in outpatient facilities and medical office buildings. (Useable space is calculated as approximately 85% of gross building area).

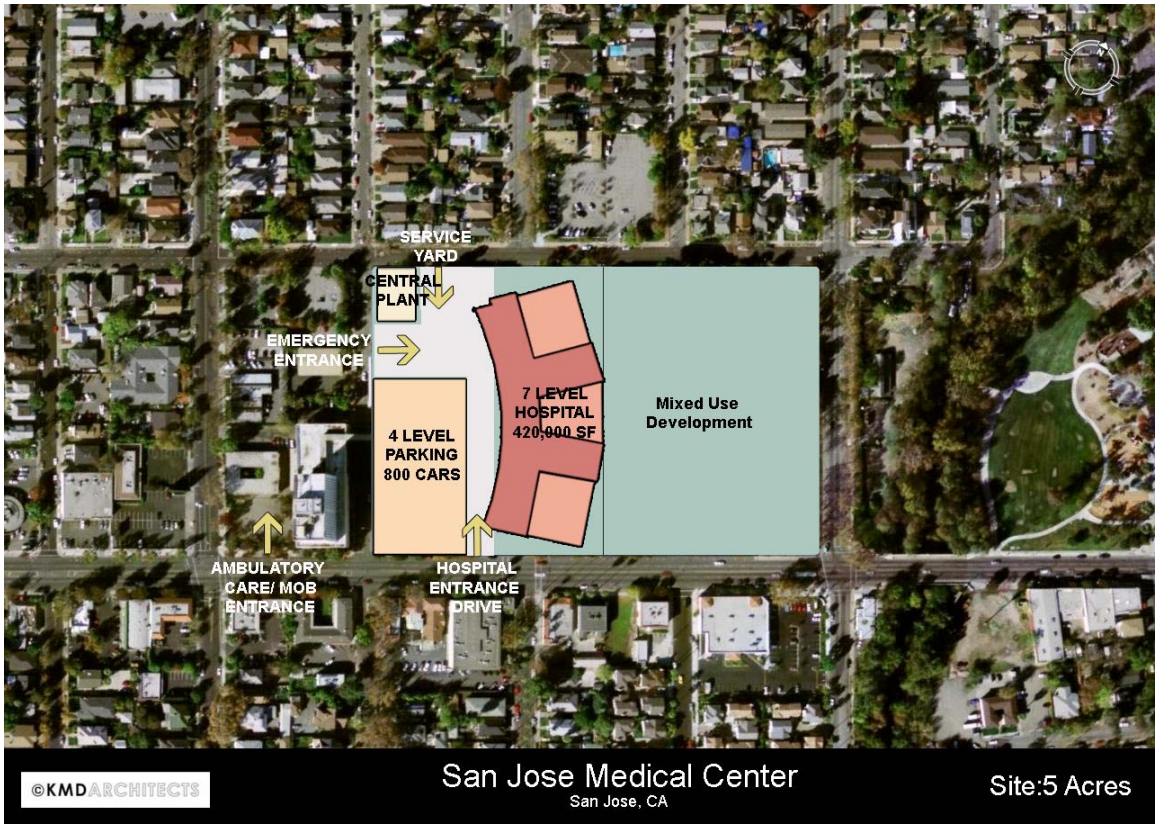
Good hospital and campus planning must also anticipate and provide ways to accommodate:

- Incremental (and non-uniform) growth for expansion of successful services, space for new initiatives, new and changing technologies
- Sites for phased replacement of facilities as they become obsolete.

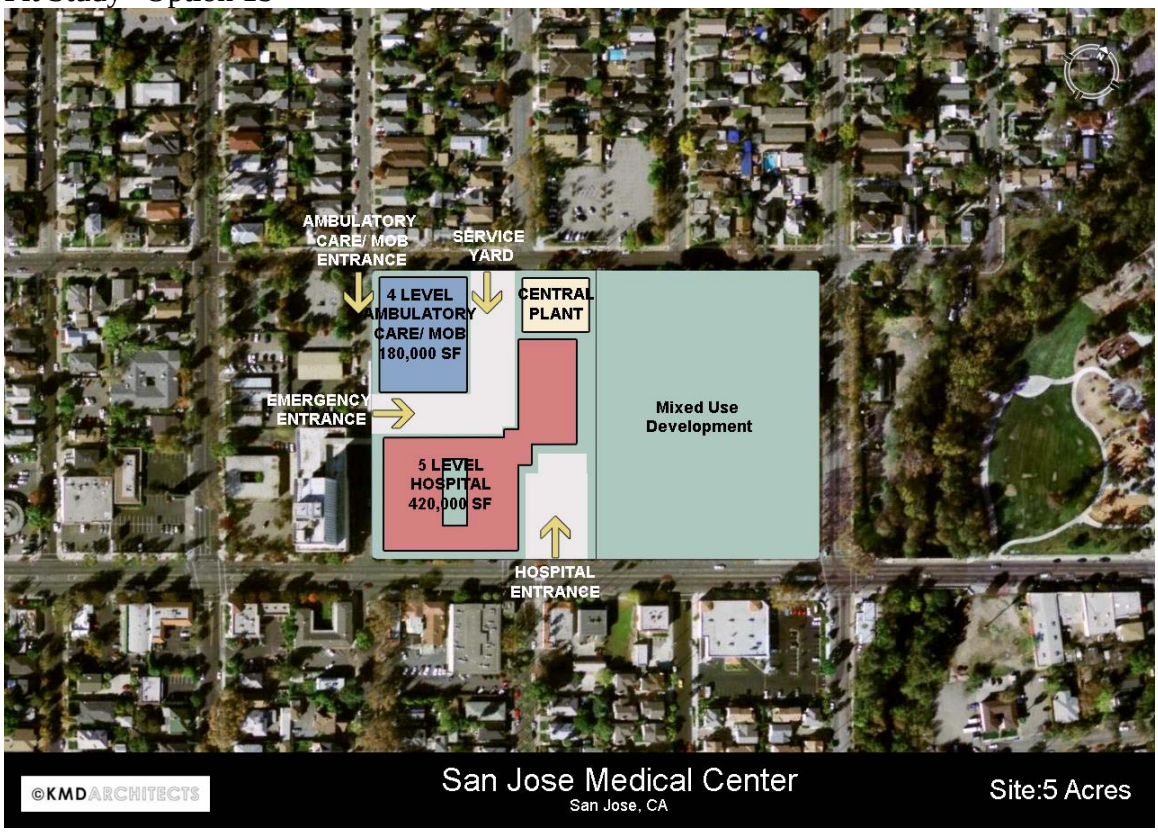
Below are four diagrams that illustrate alternative patterns for site development, each roughly based on a contemporary facility of comparable size.



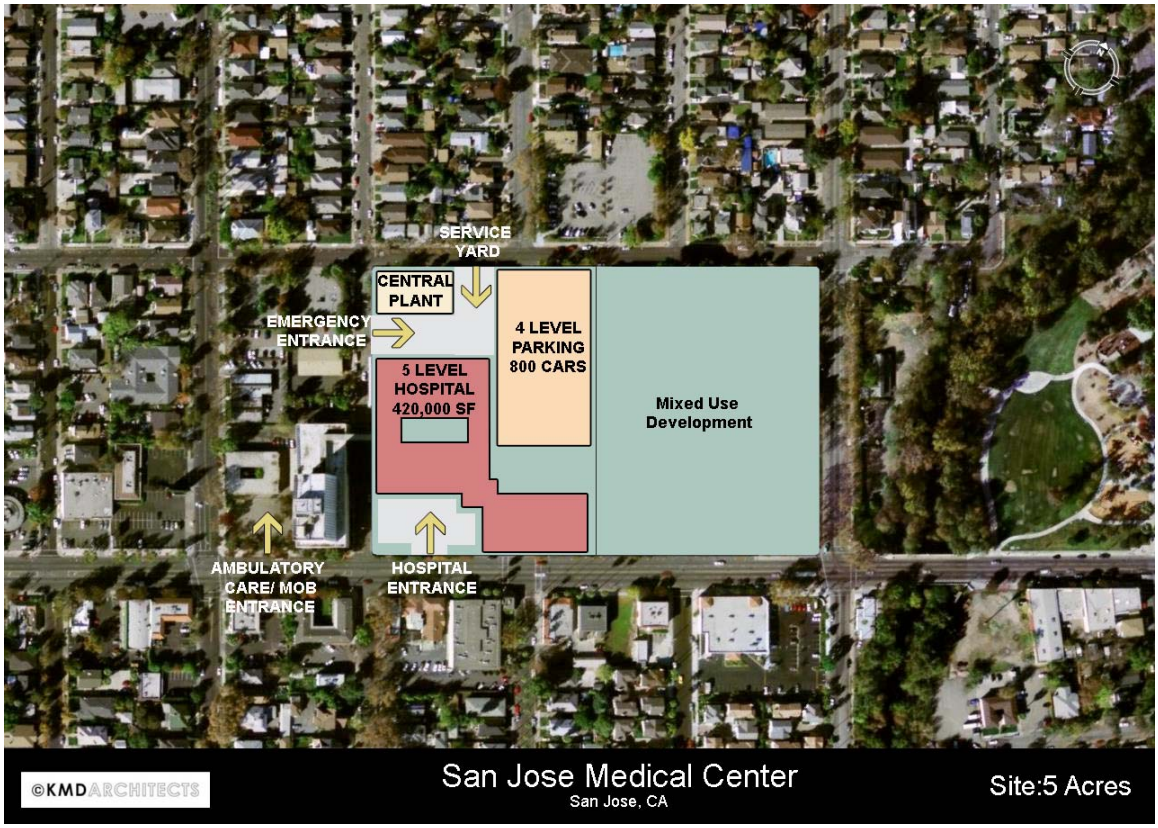
Fit Study "Option 1a"



Fit Study "Option 1b"

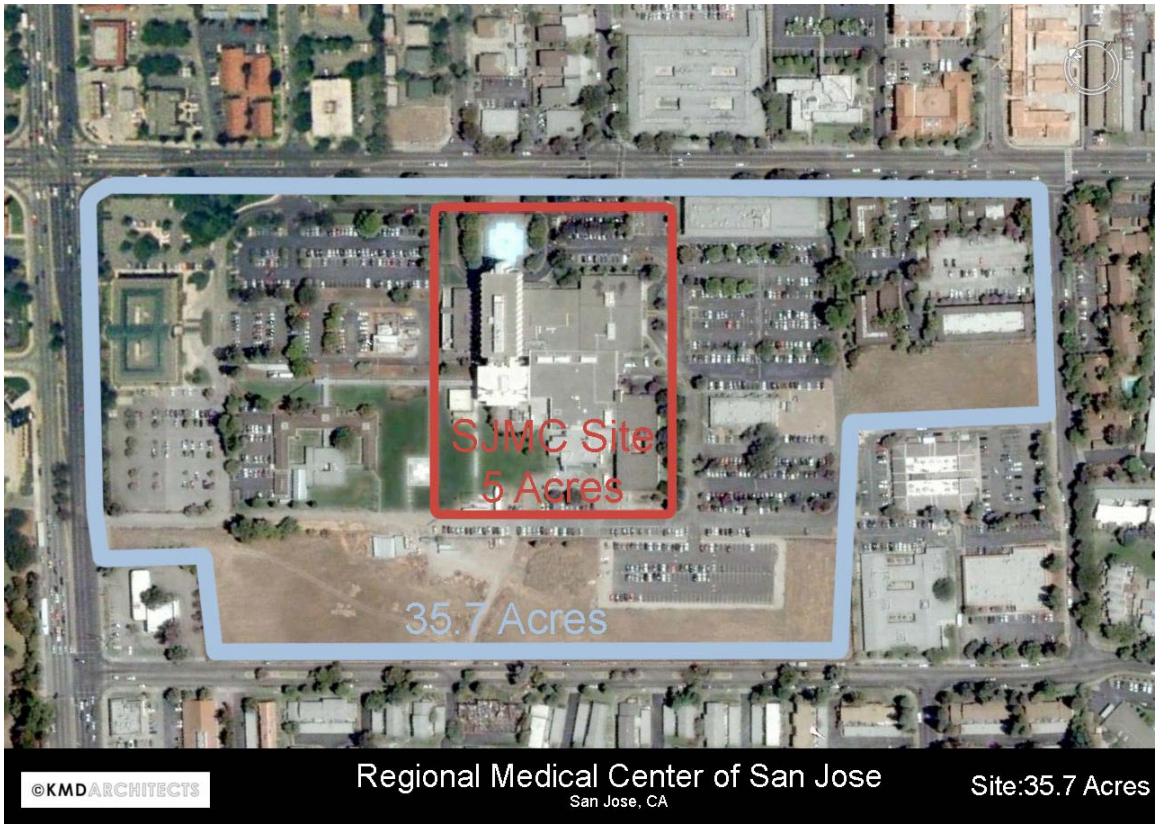


Fit Study "Option 2a"



Fit Study "Option 2b"

Examples of other campuses for hospitals with similar number of beds to that proposed for the SJMC site have also been identified. The areas of those campuses have been compared to the proposed allocated five acres on the SJMC site. In every case (particularly for hospitals having new or proposed facilities), the campus areas exceed that which would be available at the SJMC site. (Site boundaries, where not clearly identifiable, have been assumed on the basis of available information to KMD).

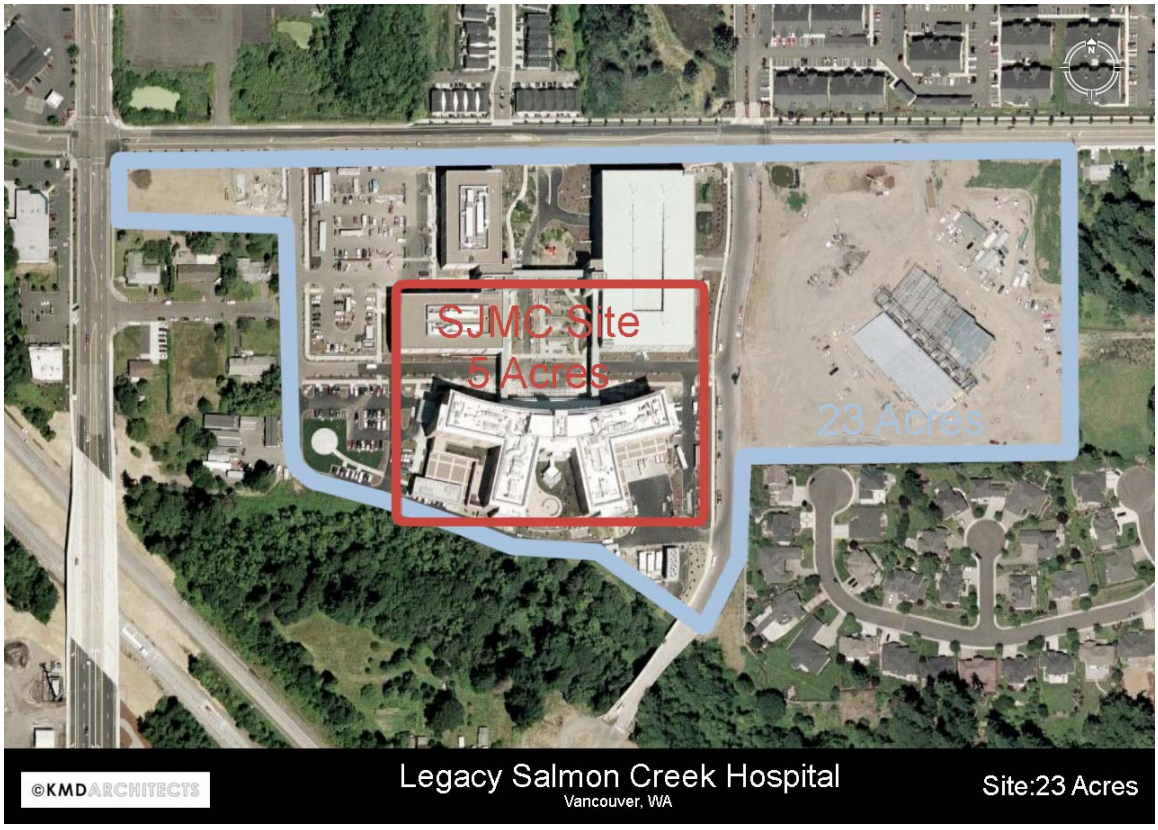

SJMC Site
5 Acres
35.7 Acres
©KMDARCHITECTS
Regional Medical Center of San Jose
San Jose, CA
Site:35.7 Acres

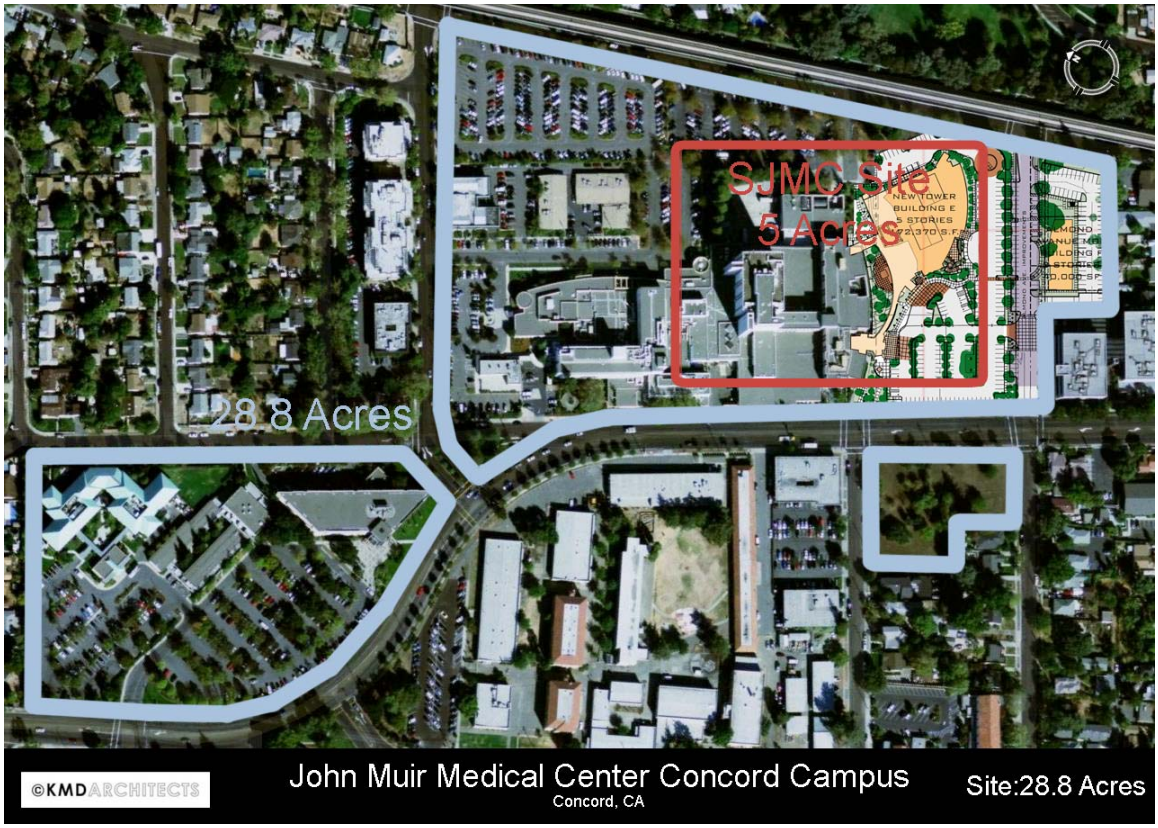

17 Acres
SJMC Site
5 Acres
©KMDARCHITECTS
O'Connor Hospital
San Jose, CA
Site:17 Acres


SJMC Site
5 Acres
20 Acres
©KMDARCHITECTS
Kaiser - Redwood City
Redwood City, CA
Site:20 Acres


35 Acres
SJMC Site
5 Acres
©KMDARCHITECTS
Washington Hospital
Fremont, CA
Site:35 Acres


PROPOSED PARKING STRUCTURE
PARK PAVILION
PARK PAVILION EXPANSION
NORTH DRIVE
EXISTING POST PARTUM
WILLOW
ORCHARD
SJMC Site
5 Acres
PROPOSED HOSPITAL BUILDING
NORTH ADDITION
HOSPITAL DRIVE
EXISTING CENTRAL PLANT
SURFACE PARKING
27 Acres
©KMDARCHITECTS
El Camino Hospital
Mountain View, CA
Site:27 Acres

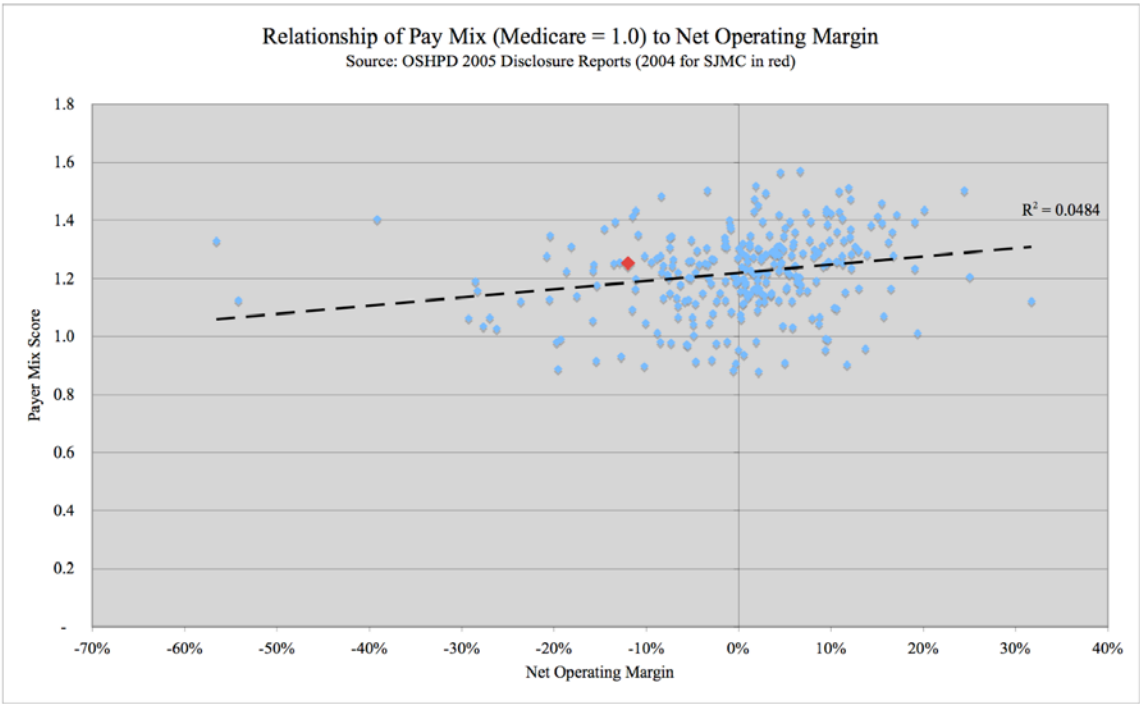

SJMC Site
5 Acres
23 Acres
©KMDARCHITECTS
Legacy Salmon Creek Hospital
Vancouver, WA
Site:23 Acres



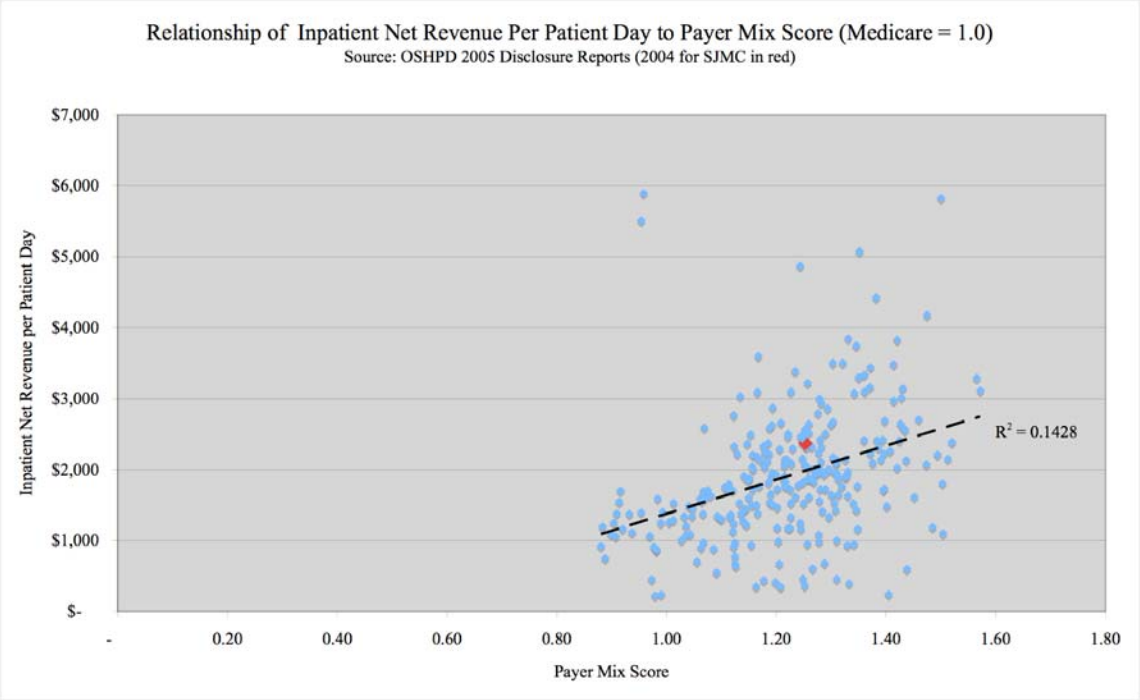
These area comparisons further support the conclusion that the SJMC property is not practical for development of a contemporary hospital of moderate size.

Appendix

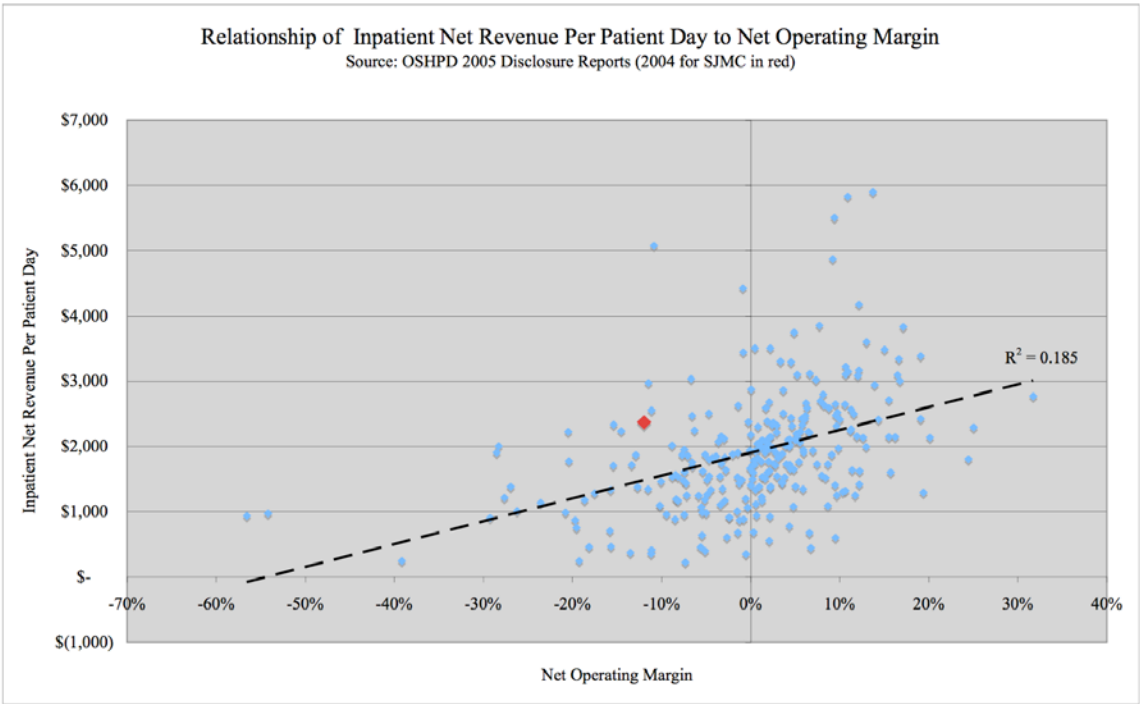
It is possible to obtain a measure of the relationship between payer mix and net operating margin among California community acute care hospitals. In order to do so, it is necessary to calculate a payer mix score for California hospitals. Indexing other payer groups to Medicare where the Medicare reimbursement per patient day score is 1.0 accomplishes this. The Medi-Cal and County average score is 0.73; third party average score is 1.92; and "other" average score is 0.95. A blended average score for each hospital is determined based upon proportion of charges attributable to each payer group.



There is less than a 5% chance that payer mix can predict net operating margin in California hospitals, which may lead one to ask if payer mix is a good predictor of inpatient net revenue per patient day.



While payer mix and inpatient net revenue have a stronger relationship (14%), the relationship is still very weak. A final question one might ask is whether there is a meaningful relationship between inpatient net revenue per patient day and net operating margin.



While the inpatient net revenue per patient day and net operating margin have a little stronger relationship (19%), it is still weak.

It does not appear to be possible to build a predictive model of net operating margin from payer mix or inpatient net revenue per patient day.

SJMC net operating margin suffered for a number of reasons. Payer mix was relatively poor. Case mix intensity was very high. Services were very costly. Facilities were very old and inefficient.